

Introduction

Environment of Change Surrounds VA Mission

The mission so nobly described by Abraham Lincoln as “Caring for those who shall have borne the battle” represents a single constant, surrounded by constant change.

The one, unchanging feature attending Mr. Lincoln’s charge to provide health care for America’s veterans is that the nation regards it as a duty of the highest priority. But how that job is done – at what kind of facilities, where they are located, and which types of procedures are used – has been subject to dynamic change, as a function of medical advances, modern health care trends, regional migration and other factors.

This document embodies the plan for managing a vital element of that change: the capacity and placement of facilities, their accessibility and the acute care infrastructure necessary to meet the current and future needs of veterans. The underlying planning process is entitled “Capital Asset Realignment for Enhanced Services (CARES), and the foundational CARES Plan includes:

- Findings from an objective comparison of data on future needs versus current capabilities;
- A comprehensive assessment of the adequacy of all current VHA health care space to meet these needs;
- An investment strategy to guide the allocation of capital resources to meet those space needs;
- Exploration of alternative use of campuses to benefit veterans, such as assisted living facilities or other compatible uses, with revenues used to invest in veteran services;
- Adopting the Critical Access Hospital (CAH) model developed by the Centers for Medicare and Medicaid Services for small facilities as a guide to ensure that quality of care is maintained in the future;
- A description of consolidations of services and realignments to replace inefficient, aged campuses with modern facilities to improve quality and cost effectiveness;
- A description of internal collaborations between the three VA administrations and external collaborations with the Department of Defense (DoD) to maximize joint utilization of capital resources; and
- A description of stakeholder involvement in the CARES process.

Background Includes Transformational Changes

A brief word of background on the federal entity charged with caring for America’s veterans may help to place the CARES process and this plan into perspective. This entity is the Department of Veterans Affairs (VA). Many changes in VA’s health care system have come through gradual evolution, but there also have been instances of remarkable transformation. After World War II, for example, VA astounded critics by accomplishing a dramatic and highly successful expansion to meet the needs of millions of World War II veterans.

VA's health care system – in modern parlance, the Veterans Health Administration (VHA) – was transformed again in the 1990's. Having initially lagged behind the national trend of placing greater reliance on primary care and outpatient settings, VHA accomplished a reinvention of major proportions.

In just seven years – from 1995 to 2002 – VA changed from an inpatient model of care characterized by a limited number of specialized facilities, to an outpatient model with more than 1,300 access sites in veterans' communities across the United States. Acute operating beds were reduced from 52,000 to about 19,000, and the inpatient average daily census dropped about 60 percent in this period. Most telling, by 2002, the VA was treating more than 1.5 million additional veterans annually – an increase greater than 50% since the beginning of the period.¹

A key element of the reorganization was dividing the VA system into strategic networks. There are currently 21 of these Veterans Integrated Service Networks, commonly referred to as "VISNs." VISNs are focal points for coordinating medical services in a population-based approach to care. In a few short years, VISNs guided VA's transformation into a system of highly efficient, ambulatory-based care, backed by a highly integrated system of tertiary care and other services.

Echoes of Change: Reverberations Linger

Reverberations can linger in the wake of such remarkable changes in the VA health care system. For example, when VA geared up to care for World War II veterans, medical staffs were augmented virtually overnight (through affiliation with the nation's medical schools). Necessary expansion of the infrastructure took much longer – with site selection, design, funding, and construction of VA facilities around the country stretching through the 1950's and 60's.

The more recent reformation of VA health care during the 1990's – creating today's efficient, primary care focused, outpatient-based system – was also followed by reverberations. While making strong progress in refining primary care modalities and expanding access through investments in community based clinics, VA had limited success in securing capital to maintain its acute care infrastructure.

Initial restructurings, such as reducing bed numbers, closing staffed wards, changing specific use of buildings, etc., were accomplished with dispatch. But further steps were problematic, since disposition of capital assets traditionally has been a difficult process in the Federal sector in general, and in the VA, in particular. In addition, vacant space may be scattered and not concentrated in specific locations amenable to closure or re-use. To some extent, the lack of concentrated space simply reflects the nature of physical plant entities, i.e., vacant and underutilized buildings (many of which have historic value) cannot be moved around like most other resources. Disposing of such assets can be a complex process for any department or agency. For VA, periodic,

¹ Source: Department of Veterans Affairs Program Statistics, April 17, 2003

vigorous opposition from local interest groups who object to the proposed re-use of the facility or land has complicated this difficult task.

GAO Paints Challenge in Stark Terms

In view of this background, it was not particularly surprising when, in 1999, the General Accounting Office (GAO) gave VA poor marks, for its record in divesting itself of vacant and underutilized buildings. Some details in the GAO comments were noteworthy, such as the contention that, unless VA implemented more effective capital investment planning and budgeting, it could “spend billions of dollars operating hundreds of unneeded buildings over the next 5 years or more.”²

Although the GAO financial estimate were based upon complete campus closures (not closing/demolishing individual buildings at over 150 sites), which are not fully achievable, VA embraced the recommendation to strengthen capital investment planning – because the GAO’s conclusion was in perfect accord with VA’s own goals for the direction of its health care system. This GAO conclusion was that “VA could enhance veterans’ health care benefits if it reduced the level of resources spent on underused or inefficient buildings, and used these resources instead to provide health care more efficiently in existing locations or closer to where veterans live.”³

Congressional authorizing, appropriating and oversight committees had also expressed concern over the lack of a long-term capital planning process.

Designing a Tool of Unprecedented Precision

In designing the CARES process, VA explicitly followed GAO recommendations, such as working to eliminate subjective judgments, developing methods to quantify the benefits of locations and facilities, and seeking the best-defined measurement standards. The completed CARES design therefore differed from previous planning and budgeting efforts in several important respects. CARES was:

Comprehensive – the systematic assessment of the condition and functionality of current space and requirements to meet projected changes in the demand for services was applied throughout the VA system.

Data driven – the use of market-specific actuarial projections brought a new level of credibility to the assessment of future veterans’ needs in well-defined health care markets.

Objective – “gaps” in service (disparities between current capabilities and future needs) were identified based solely on clear-cut application of “threshold criteria.”

² VA Health Care: Capital Asset Planning and Budgeting Need Improvement (GAO/T-HEHS-99-83, Mar. 10, 1999)

³ VA Health Care: Improvements Needed in Capital Asset Planning and Budgeting, GAO/HEHS-99-145 (Washington, D.C.: Aug. 13, 1999), p.4

Systematic – planning initiatives and their resolution in market plans followed a set of system-wide assessment and projection methodologies and tools based upon national data sources.

Most Distinguishable Characteristic – Stakeholder Involvement

One piece of GAO advice, in particular, led to one of the defining characteristics of CARES. This area of GAO commentary involved the diverse groups of publics with whom VA health care is intimately involved at many levels.

GAO asserted that these groups have not always had an appropriate role in dealing with VA capital assets. According to the GAO, these publics should be involved in an active advisory role in developing procedures, criteria, etc., for CARES. GAO pointed out that the involvement of these public groups not only facilitates receiving valuable perspectives from them, the GAO stated, but also enhances understanding of and builds support for the process.⁴

The importance VA placed on these publics was reflected by the fact that they were termed “stakeholders” in the CARES process. The resources and policies devoted to ensure that they were part of the process further attested to their importance. Stakeholders included veterans service organizations, VA employees, academic affiliates, Department of Defense sharing partners, and the congressional delegations that represent all the other publics. Chapter 3 of this plan details the unprecedented level of interaction between VA and these stakeholders during the design and application of CARES.

Meeting the CARES Deadline

The “roll out” of CARES began on June 5, 2002, when Secretary of Veterans Affairs Anthony J. Principi announced the initiation of the CARES process. Fourteen months later, on August 1, 2003, this Draft National CARES Plan was presented to the CARES Commission. (The role of the Commission and the overall CARES timetable are explained in Chapter 2.)

This relatively short development period for such a complex planning process reflects that the CARES timetable had an absolute deadline: to have an approved National CARES Plan in time to meet congressional target dates for capital funding proposals for FY 2005 and FY 2006.

At the time this draft was published, it was anticipated that the completed and fully reviewed National CARES Plan would be ready for the Secretary’s decision by the end of December 2003 – which would meet the stipulated deadline for the first of these fiscal year budget cycles.

In building a virtual roadmap for veterans’ health care in the future, the CARES process combined state-of-the-art statistical methodologies with thorough, pragmatic planning

⁴ VA Health Care: VA is Struggling to Address Asset Realignment Challenges, GAO/HEHS -00-88 (Washington, D.C.: April 5, 2000), p.5

analyses. This complex undertaking was the first comprehensive, long-range assessment of the VA health care system's capital requirements since 1981, when a multi-year effort known as the Medical District Initiated Planning Process (MEDIPP) conducted a similar, if less sophisticated, system-wide appraisal.

Developing the Draft National CARES Plan in such a short time period was a formidable task. Despite the fact that a detailed "CARES Guide and Operating Plan" was prepared and distributed to VA planning teams in advance, full implementation of the process required many adaptations and temporary solutions. Ultimately, some limitations in the CARES process had to be accepted, with the understanding that improvements would be made when the process was integrated with VHA's regular strategic planning process. While the CARES pilot was instructive in demonstrating the importance of stakeholder participation, it was a contracted study performed by a consultant in a single VISN.⁵

The CARES pilot did not provide the tools, technical methodologies or processes to extend the process to the entire VA health care system. These tools had to be developed in real time, without benefit of full testing. Implementation began with unfamiliar databases, and an incomplete understanding of the interrelationships and policy implications of a complex set of data, methodologies and processes.

As indicated in the succeeding chapters, many improvements were made as the plan developed and the knowledge base improved. At the time this Draft National CARES Plan was published, improvements in the process were still underway, notably including those required to develop credible forecasts of the need for Nursing Home Care, Domiciliary Care and selected mental health components. Inclusion of these three program areas was therefore postponed until the next VHA strategic planning cycle.

CARES Plan Had Numerous Authors

Credit for the CARES process and for this plan is due literally hundreds of men and women across the nation who devoted a great deal of time and energy to this effort.

Some contributors devoted long hours of complex, diligent work – in addition to regular job responsibilities. Yet all of those involved – from the designers of the process, to the statisticians who ran the data, to the program experts who constructed models for special disabilities, to the network planning teams comprised of planners, clinicians and administrators who brought the numbers to life – gave CARES the attention and the respect it deserved as a key element in the future of VA medical programs.

The largest group of contributors was comprised of the many stakeholders in the VA system, prominently including America's veterans service organizations. Their active participation – learning about CARES, providing advice at various stages of the process, and commenting on findings and proposals – was fundamental to the program's integrity.

⁵ The role of the pilot program in VISN 12 as the first step in the phased implementation of CARES is discussed in Chapter 2.

Because of the collective involvement of these numerous “authors” of this CARES Plan, the Department of Veterans Affairs stands poised to fulfill its long term planning mission: “to improve access to, and the quality and cost effectiveness of, veterans health care.”